

511 Medical Plaza Drive, Suite 101, Leesburg, FL 34748  
phone 352.728.6808 fax 352.728.1743  
[fhvhealth.com](http://fhvhealth.com)

To our new patient,

**Welcome!** On behalf of the staff at FHV Health, we would like you to know that we are honored to have you as a new patient to our practice. We look forward to providing you with the highest quality of care from the best trained technical staff Florida has to offer. We provide a variety of treatment plans and procedures using the most sophisticated medical equipment in the area.

Enclosed you will find several forms that will need to be completed by your first appointment date. These forms will be available in the front office on the day of your appointment, but we wanted you to have the option to fill them out from the comfort of your home, if you prefer.

As a patient of FHV Health, you have round-the-clock access to a nurse or health care professional. If you are sick or need medical advice, you can always **call us first at 352-205-4439**. When you dial our 24/7 health care hotline, a trained health care professional will advise you on whether you should visit your primary care provider, our Urgent Care Center, or an emergency room.

Please remember these important things regarding your first visit to our office:

- Bring **all** your medications in a bag to **each** office visit.
- Sign the enclosed "Record Release" form for us to obtain previous records of your care.
- Keep us updated on studies or surgeries you've had since we last saw you. If you spend part of the year in another area, be sure to bring copies of any studies back with you or mail them to us.
- If you have any questions or concerns, feel free to call us during business hours at **352-728-6808** or visit **[fhvhealth.com](http://fhvhealth.com)**. We promise to do everything we can to get you the information you need.

Once again, welcome to FHV Health. We look forward to your visit with us.

**Yours in Health,**

FHV Health Physicians and Staff

\_\_\_\_\_  
PATIENT PRINTED NAME

\_\_\_\_\_  
DATE OF BIRTH

## Medical Release Authorization

I hereby authorize and request \_\_\_\_\_ to release medical information concerning my medical care to FHV Health for the following purpose(s):

\_\_\_\_\_  
SPECIFIC PURPOSE FOR DISCLOSURE OF RECORD

The type and amount of information to be disclosed is as follows: *(Specify dates where appropriate)*

- |                                |  |
|--------------------------------|--|
| _____ History and physical     | _____ Stress test reports                    |
| _____ Discharge summary        | _____ Cardiac catheterization reports/images |
| _____ Lab results              | _____ Peripheral ultrasound reports          |
| _____ EKGs                     | _____ Abdominal ultrasound reports           |
| _____ Echocardiogram reports   | _____ Carotid ultrasound reports             |
| _____ Chest x-ray reports      | _____ Peripheral angiogram reports/images    |
| _____ Most recent office notes | _____ Other, please specify: _____           |

I understand that the information may include the release of information concerning HIV testing or treatments of AIDS or AIDS-related conditions, drug or alcohol abuse (or related conditions), and mental health conditions.

I understand the use or disclosure of my individual health information, as described above. I understand that this authorization will expire, without my express revocation, either one year from the date of signing or, if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that this authorization is revocable, upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation, and that it may be re-disclosed by the recipient. The facility, its employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein. **Please fax records to 352.728.1743.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE



## Information Regarding the Health Insurance Portability & Accountability Act

**This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please read it carefully.**

The **Health Insurance Portability & Accountability Act (HIPAA)** of 1996 is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, to be kept properly confidential. This Act gives you, the patient, rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are maintaining the privacy of your health information and how we may use and disclose your health information.

We at FHV Health create a medical chart with your personal medical information, along with a computerized account for payment. Treatment: We may use and disclose information about you to provide you with medical care. We may disclose information about you to other physicians or those designated on the "Authorization To Release Information." Payment: We may use medical information, along with Insurance information, and any additional information provided, in order that payment for services is received. Operations: We may use and disclose PHI from you for normal daily medical operation of our office. We may also disclose information to our Business Associates who provide contracted services for us (accounting, legal representation, claims processing, consulting, etc.). We may contact you to remind you of appointments, health related issues, or billing concerns. Every effort will be made to comply with any particular request or restriction designated in writing.

### Your Rights Regarding Medical Information About You

(1) You have the right to request restrictions on certain uses and disclosures of Protected Health Information. We are however not required to agree to a requested restriction and should we not agree may request you seek another physician. (2) The right to reasonable requests to receive confidential communication of protected health information from us. This request must be in writing. (3) The right to request an amendment. Should you feel the medical information is incorrect or incomplete, you may request an addition or amendment. Requests must be made in writing and submitted to FHV Health, with attention to your attending physician. If you desire your medical record to be changed there is a form, which will be sent to you. The physician may decline your request if it's not accurate. (4) Right to an Accounting of Disclosures. You have a right to request a list of certain types of disclosures we have made of your medical information. We are not required to account for disclosures that were authorized by you, to carry out treatment, payment and healthcare operations.

**I have read the Health Insurance Portability & Accountability Act of 1996 and understand my rights.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED FIRST NAME

\_\_\_\_\_  
PRINTED LAST NAME



## HIPAA Patient Consent Form

I consent to the use or disclosure of my protected health information by FHV Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of FHV Health. I understand that diagnosis or treatment of me by FHV Health physicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. FHV Health is not required to agree to the restrictions that I may request, and may request I seek another physician. However, if FHV Health agrees to a restriction that I may request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that FHV Health has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The FHV Health Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the FHV Health. The Notice of Privacy Practices for FHV Health is also provided in the reception area. This notice of Privacy Practices also describes my rights and the FHV Health duties with respect to my protected health information.

FHV Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

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DATE



## Authorization for Disclosure of Health Information

Many of our patients allow family members, such as their spouse, significant other, parents and/or children to call and request results of tests, procedures and financial information. Under the requirements of HIPAA, we are not permitted to give this information to anyone without the patient's written consent.

If you wish to have your medical information, diagnostic test results, and/or financial information released to any individuals or family members, you must sign and list them on this form.

The facility, its employees and physicians, are hereby released from any liability for the disclosure of information released therein. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize FHV Health to release any or all information concerning my medical care to the following individuals:**

|      |                         |              |
|------|-------------------------|--------------|
| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |
| NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER |

I authorize FHV Health to leave normal test results on my answering machine or voicemail.

|                      |               |     |
|----------------------|---------------|-----|
| PATIENT PRINTED NAME | DATE OF BIRTH | SSN |
| PATIENT SIGNATURE    | DATE          |     |
| WITNESS SIGNATURE    | DATE          |     |



## Medical History Questionnaire: Cardiology

|  |     |                       |
|--|-----|-----------------------|
| PATIENT PRINTED NAME                         |     | DATE                  |
| SEX  | AGE | RACE/ETHNICITY        |
| OCCUPATION (IF RETIRED, PREVIOUS OCCUPATION) |     | ALLERGIES             |
| PHARMACY                                     |     | PHARMACY PHONE NUMBER |
| PRESENT ILLNESS                              |     |                       |

**Past Medical History:** If you have a history of any of the following, please check the box:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> High cholesterol<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> Palpitations (rapid heart beat)<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Stroke or mini strokes<br><input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Nervous condition<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Peptic ulcer<br><input type="checkbox"/> Gall bladder disease<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Bleeding disorder<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Radiation treatment<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Cataracts | <input type="checkbox"/> Respiratory arrest<br><input type="checkbox"/> Abdominal aortic aneurysm<br><input type="checkbox"/> Cardiac arrest <i>Date:</i> _____<br><input type="checkbox"/> Hiatal hernia<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bladder infections<br><input type="checkbox"/> Gout<br><br><b>Other</b><br>_____<br>_____<br>_____ |
|--|--|---|

**Physicians:** Please list the names and contacts of all physicians who you are currently under care of:

|                       |           |                     |
|-----------------------|-----------|---------------------|
|                       |           |                     |
|                       |           |                     |
|                       |           |                     |
|                       |           |                     |
|                       |           |                     |
| OFFICE/PHYSICIAN NAME | SPECIALTY | OFFICE PHONE NUMBER |

## Medical History Questionnaire: Cardiology

### Past Surgical History (Include date)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

### Medications (Include dosage)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

### Procedures: If you have had any of the following, please check the box and note the date:

- |   |   |
|---|---|
| <input type="checkbox"/> Electrocardiogram (EKG) <i>Date:</i> _____ | <input type="checkbox"/> Automatic Implantable Cardioverter<br>Defibrillator (AICD) <i>Date:</i> _____                              |
| <input type="checkbox"/> Stress test <i>Date:</i> _____             | <input type="checkbox"/> Cardioversion (electric shock delivered to the heart to<br>convert irregular heartbeat) <i>Date:</i> _____ |
| <input type="checkbox"/> Echocardiogram <i>Date:</i> _____          | <input type="checkbox"/> Balloon angioplasty of any heart arteries <i>Date:</i> _____   |
| <input type="checkbox"/> Holter monitor <i>Date:</i> _____          |   |
| <input type="checkbox"/> Permanent pacemaker <i>Date:</i> _____     |   |

### Review of Symptoms: If you have had any of the following within the past year, please check the box:

- |   |   |
|---|---|
| <input type="checkbox"/> Fainting spells  | <input type="checkbox"/> Shortness of breath when walking several blocks      |
| <input type="checkbox"/> Dizziness when changing positions                                      | <input type="checkbox"/> Shortness of breath when climbing a flight of stairs |
| <input type="checkbox"/> Swelling in hands, feet or ankles<br><i>At what time of day?</i> _____ | <input type="checkbox"/> Purple lips or fingers                               |
| <input type="checkbox"/> Unconscious spells   | <input type="checkbox"/> Heart palpitations or flutters                       |
| <input type="checkbox"/> Chest pain   | <input type="checkbox"/> High blood pressure                                  |
| <input type="checkbox"/> Angina   | <input type="checkbox"/> Leg cramps when walking or at night                  |
| <input type="checkbox"/> Pain in arm(s)   | <input type="checkbox"/> Recurrent stomach pain                               |
| <input type="checkbox"/> Pain in jaw  | <input type="checkbox"/> Belching or heartburn relieved by food/medication    |
| <input type="checkbox"/> Coughing up blood  | <input type="checkbox"/> Nausea or vomiting                                   |
| <input type="checkbox"/> Frequent cough while laying down                                       | <input type="checkbox"/> Vomited blood  |
| <input type="checkbox"/> Waking with shortness of breath  | <input type="checkbox"/> Blood in bowel movement                              |
| <input type="checkbox"/> Shortness of breath when laying down                                   | <input type="checkbox"/> Tiredness without apparent reason                    |
|   | <input type="checkbox"/> Night sweats   |



## Medical History Questionnaire: Cardiology

**Additional questions:** Please answer the following questions:

How many pillows do you use at night? \_\_\_\_\_

Have you ever been on a respirator/breathing machine?  Yes  No If yes, for how long? \_\_\_\_\_

Do you have a cardiac catheter?  Yes  No If yes, when was it implanted? \_\_\_\_\_

At what hospital? \_\_\_\_\_

Do you use oxygen at home?  Yes  No If yes, how many liters? \_\_\_\_\_ Times per day? \_\_\_\_\_

**Social history:** Please answer the following questions:

Any current/former tobacco use?  No  Yes, former user  Yes, current user  
 If yes, how much? \_\_\_\_\_ For how long? \_\_\_\_\_  
 If former user, when did you quit? \_\_\_\_\_

Alcohol use?  Yes  No If yes, how often? \_\_\_\_\_

Caffeine use?  Yes  No If yes, how often? \_\_\_\_\_

Marital status?  Single  Married  Divorced  Separated  Widowed

Have you ever been pregnant?  Yes  No If yes, how many times? \_\_\_\_\_

How many children were born alive? \_\_\_\_\_ How many cesarean section deliveries? \_\_\_\_\_

**Family History:**

| RELATION        | AGE   | HEALTH | AGE AT DEATH | CAUSE OF DEATH |
|-----------------|-------|--------|--------------|----------------|
| <b>Father</b>   | _____ | _____  | _____        | _____          |
| <b>Mother</b>   | _____ | _____  | _____        | _____          |
| <b>Siblings</b> | _____ | _____  | _____        | _____          |
| _____           | _____ | _____  | _____        | _____          |
| _____           | _____ | _____  | _____        | _____          |
| <b>Children</b> | _____ | _____  | _____        | _____          |
| _____           | _____ | _____  | _____        | _____          |
| _____           | _____ | _____  | _____        | _____          |
| _____           | _____ | _____  | _____        | _____          |

If any of your blood relatives have had any of the following, please check the box:

- Heart disease *Who?* \_\_\_\_\_
- Stroke *Who?* \_\_\_\_\_
- High Blood Pressure *Who?* \_\_\_\_\_
- Thyroid Disease *Who?* \_\_\_\_\_
- Diabetes *Who?* \_\_\_\_\_
- High Cholesterol/Triglycerides *Who?* \_\_\_\_\_